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LETTERS TO THE EDITOR

Funding for Graduate Medical Education

I wish to comment regarding Dr. Parmley's statements concerning funding for graduate medical education (1).

I respect Dr. Parmley greatly and share his concern for the uncertain future we in medicine face. However, I disagree with his emphasis that the changes will adversely affect the production of cardiologists. I think I speak for the majority of private practice cardiologists today when I say there are already too many cardiologists in the United States. Even if all the programs took no more new fellows there are already so many in the pipeline in training that we will still be faced with a large surplus in the near future. What happened in the private practice of the subspecialty of cardiology is there never was any measure of how many cardiologists were needed and we now have one on every corner. I believe this occurred because the numbers grew mostly to supply cheap labor to fuel the voracious appetite of the "publish or perish" machine during a time when explosive advances were taking place in basic knowledge and technology. Unfortunately, quantity won out over the never-ending battle between quantity and quality.

Truly, in the absolute sense the best scheme for balanced production of a quality product must include knowledge of the ultimate needs to be met. Then, measuring the resources at hand the product can have the greatest amount of refinement possible. For the cardiologist this would be measured by the depth and breadth of his experience as it would by any of the specialists who set themselves before the public as experts in a particular field. Unfortunately, with the changes in medical training that occurred during the early 70s with the dropping of one year from basic internal medicine training and the emphasis on subspecialty training, what took place was a swing away from expertise. This may appear contradictory; however, if each of us examines our own development, with few exceptions duration and quantity of experience are responsible for the quality of our expertise. The "fast track" does not produce experts except in very narrow fields. Today with the overproduction of physicians, the average cardiologist or any other subspecialist arriving in a new practice situation will find that to survive he must practice general internal medicine for the most part. This is a role for which he has been ill prepared, because while a year was being taken away from his general experience, medicine was becoming much more complex. At the same time he may have been a fellow in a program where there were 30 other fellows and much of his experience was gained doing research in the dog lab. Nevertheless, he could read texts and keep up with the latest in the escalating number of journals and ultimately pass the subspecialty boards and even become a Fellow in the American College of Cardiology. But is he really an expert with depth and breadth to whom the specialist must frustratingly turn? I say no.

What we really need in medicine is some serious determination to make the real needs of medical care of the patient met by a system structured in such a way that this patient's needs are met by experts from the very beginning. This must be done by limiting production of all physicians and in particular the subspecialist. That way those who do become finished products can truly have the greatest possible breadth and depth to their experience and are far more likely to maintain their skills because the system will insure they are needed. I dare say it will aid in reducing the number of unnecessary procedures performed on patients and in a very real way reduce the overall cost of medical care in this country. So if Congress is going to reverse itself and go for quality rather than quantity by forcing the training mills to cut back, I say God bless them.

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Reference

1 Parmley WW President's Page: Funding for graduate medical education. J Am Coll Cardiol 1985:6;715–6

Reply

Dr. Stutts' thoughts about the number of cardiologists are important because they reflect a sentiment in many parts of the country that there are too many practicing cardiologists. Because of this, the Bethesda Conference Committee has recommended to the officers of the College that a Bethesda Conference on Manpower be held to develop better data on this question. The Conference will be held this year. In a preliminary survey which was sent out to a sample of cardiologists by the Cardiology Manpower Advisory Committee, there were mixed returns on the issue of whether or not there are too many cardiologists. Many suggested, as did Dr. Stutts, that competition was a major factor and that there are now too many cardiologists in their practice area. On the other hand, many other cardiologists indicated that they were too busy and were actively trying to recruit another associate to take care of their load. The difficulty in answering this question in view of the mixed signals certainly underscores the importance of convening a Bethesda Conference to try to define the issue in greater detail.

It should be noted that the recent Bethesda Conference on Cardiology Training has recommended changes that may decrease the number of cardiologists being trained. These include a recommendation to increase the length of training to 3 years, including 24 months of clinical training. Furthermore, there is a recommendation for an additional year of training for qualification in advanced invasive techniques. If these proposals are adopted by the Boards, I believe that the end result will be to decrease the numbers of cardiologists who are coming out of the pipeline at the end of their training.

With reference to my President's Page on training, I feel that cardiologists are being discriminated against in the graduate med-

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ical education funding proposals currently in Congress. Medical subspecialties appear to have been singled out for decreases in funding. The potential ripple effect that an abrupt cutoff in funding for subspecialties might have with other agencies or funding sources could produce a square-wave reduction in our training programs. Uncertainties regarding such a square-wave effect have prompted concern among a number of us that this issue must be approached more gradually and with more firm data in place before making such abrupt decisions.

I share some frustration with Dr. Stutts in that although some programs have cut back modestly on the number of individuals trained, there has not been an overall reduction in the number of cardiology fellows. Furthermore, it does not appear that the ongoing recertification of internal medical programs is likely to make much of a dent in cardiology training programs of lesser quality. I also concur that high quality training of fewer numbers would appear to be an important direction to take. These directions are now outlined for us by the recent Bethesda Conference on Training and perhaps will be enhanced further by the Bethesda Conference on Manpower which is scheduled for 1986.

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Preventive Cardiology Academic Award

The National Heart, Lung, and Blood Institute again announces the availability of this 5 year Award which will be made to successful applicant schools of medicine and osteopathy throughout the United States. Since 1979, the Preventive Cardiology Academic Award program has made 32 awards, with four more selected to start in July, 1986.

The Award program fosters initiation of high quality preventive cardiology curricula and improvement in preexisting curricula by stimulating both research and careers in the area of primary prevention of cardiovascular disease and also in the area of treating existing cardiovascular disease to reduce disability and further complications.

The major outcome of the program has been an increased level of awareness and expertise in preventive cardiology among the young doctors and medical students who will become the medical practice, teaching and research community of the future. Cardiovascular risk appraisal techniques have been developed; successful approaches to risk reduction have been formulated; preventive cardiology clinics have been established or expanded; and there has arisen an active network of awardees and alumni that exchanges information and recommendations about preventive cardiology curricula, clinics, research and software teaching tools.

The NHLBI encourages your teaching institution to apply for this Award. Guidelines may be obtained from the office of:

CURT D. FURBERG, MD
Associate Director
Clinical Applications and Prevention Program
DECA, NHLBI, NIH
Federal Building, Room 6A-14
7550 Wisconsin Avenue
Bethesda, Maryland 20892
Telephone (301) 496-1706

The deadline for application is April 1, 1986 for an Award that would start July 1, 1987.

Corrections

In Table 2 on page 728 of the October issue of the Journal, two table headings were reversed. The values listed under Post-load are those for Preload and vice-versa (Murphy-Chutorian DR, Wexman MP, Grieco AJ, Heininger JA, Glassman E, Gaull GE, Ng SKC, Feit F, Wexman K, Fox AC. Methionine intolerance: a possible risk factor for coronary artery disease. J Am Coll Cardiol 1985;6:725–30).

An error was inadvertently introduced in the first line of the right-hand column of page 1167 of the November issue of the Journal (Gang ES, Oseran D, Rosenthal M, Mandel WJ, Deng Z, Meesmann M, Peter T. Closed chest catheter ablation of an accessory pathway in a patient with permanent junctional reciprocating tachycardia. J Am Coll Cardiol 1985;6:1167–71). The line should read:
P'R interval (the RP'/RR ratio usually ranged from 0.50 to